Maryland Higher Education Commission
Office of Student Financial Assistance
6 North Liberty Street, Ground Suite
Baltimore, MD 21201
(410) 767-3300
www.mhec.state.md.us
osfamail@mhec.state.md.us

Graduate Nursing Faculty and Living Expenses Grant
Service Obligation Questionnaire

SPECIAL NOTES: Please print this form and return it to the address above. If supporting documentation is required, please include this information with your questionnaire submission. Failure to complete and return this questionnaire by the deadline may place your Graduate Nurse Faculty scholarship into repayment status. Complete only the sections that pertain to your situation.

SECTION A: Recipient Information (Please print clearly)

1. Social Security Number: ___ ___ ____ - ____ ____ - ____ ____ ____ ____Date of birth: _____/_____/_____

2. Last name: _____First name: _____MI:_____

   Previous name under which records may have been kept: _____

3. Permanent mailing address: _____

   City: _____State: _____Zip code:_____

4. Home phone: _____Work phone: _____

5. E-mail address: _____

6. Maryland college/university from which you graduated (if applicable): _____

7. Graduation date (month/year): _____Specific degree received: _____
   (if you have graduated within the past year, please attach a copy of your final transcript or copy of degree awarded)

SECTION B: Check the Situation that Best Applies to You

☐ **I am seeking to postpone (defer) my service or repayment obligation because:**

o I am currently enrolled as a full-time or part-time degree-seeking student at an institution of higher education.

Specific major: _____ Anticipated date of graduation: _____/_____/_____
(**Certification of Registrar is required**. Complete Sections C and D.)

o I am on a temporary leave of absence from employment. (Written verification from employer is required.)
Dates of leave of absence: from _____/_____/_____ to _____/_____/_____

(Over, please.)

- o I have a temporary disability that prevents me from working on at least a part-time basis. (Written verification from qualified physician is required.)
  Dates of disability leave: from _____/_____/_____ to _____/_____/_____

- o I have been unable to secure employment for a period not to exceed twelve (12) months due to the care required by a spouse or child who is disabled. (Written verification from qualified physician is required.)

- o I am actively seeking employment for a period not to exceed six (6) months beyond my date of graduation. (Recipients are required to fulfill the service obligation at any Maryland College or University which grants nursing degrees – **you are <u>not required</u> to work at the sponsor institution where the scholarship was received**).

- o I (or my spouse) have been assigned military duty outside of the State of Maryland (Please include a copy of the military orders).

- o Other **(Please include a letter of explanation)**

NOTE: Completion of the service obligation or repayment of the scholarship will be required at the end of the deferment period.

□ **I must begin repayment of the Graduate Nurse Faculty Scholarship because:**

- o I am employed in a field other than as nurse faculty (teaching).

- o I am employed outside the State of Maryland.

- o I am not licensed in nursing.

Please complete Sections C and E if you are fulfilling the following employment service:

<u>I am working full time or part time as a nurse faculty member. Fulltime employment is defined as 35 or more hours per week or a contract for 12 or more academic credit hours per didactic instruction. Part time employment is defined as 20-34 hours per week or a contract of less than 12 credit hours or combination of less than 12 academic and/or contract hours per semester.</u>

SECTION C - Recipient Certification:

I certify that the information provided by me in the questionnaire is true and complete to the best of my knowledge. I also agree to inform the Office of Student Financial Assistance, in writing, immediately upon the termination of my claimed status, or if there are any changes to name, address, place of employment or college/university study.

_____

Signature of recipient Date

SECTION D: Registrar Certification Form: (to be completed by college/university)

Student is responsible for returning completed form.

NOTE: This section of the form should only be completed if the recipient is requesting deferment due to continuing enrollment.

I certify that the student listed below is enrolled for the current semester at this college/university:

1. Social Security Number: ___ ___ ____ - ____ ____ - ____ ____ ____ ____Date of birth: _____/_____/_____

2. Last name:_____ First name:_____ MI: _____

3. Specific name of program / major:_____

4. Name of college / university: _____

5. Semester enrolled: _____

6. Enrollment status: ___ Full-time (9+ credits for graduate)
   ___ Part-time (6-8 credits for graduate)
   ___ Less than 6 credits (may result in repayment)

7. _____
   Please affix official college/university seal here

8. _____ _____
   Signature of certifying official Date

9. _____ _____
   Printed name of official Telephone

10. _____ _____
    Title of certifying official E-mail

Please return completed questionnaire to:

Maryland Higher Education Commission
Office of Student Financial Assistance
Attention: Graduate Nursing Faculty and Living Expenses Grant Program
6 North Liberty Street, Ground Suite
Baltimore, MD 21201

(Over, please)

SECTION E - Employment/Service Obligation Information:

NOTE: An Employee Information Release form must be completed for each employer who is to be considered for service obligation fulfillment. * As per your signed promissory note, you are required to work as a nurse faculty member at a Maryland institution (2) years for each year, or portion thereof, for which you received the scholarship as a full –time student or work one and one – half years as a full-time nurse faculty member for each year the award was received as a part – time student. Individuals fulfilling the service as a part – time nurse faculty member must work two years for each year of their full – time employment obligation.

1. Social Security Number: ___ ___ ____ - ____ ____ - ____ ____ ____ ____ Date of birth: _____/_____/_____

2. Last name: _____First name: _____ MI: _____

Employee Information Release Statement

I hereby authorize my employer to provide the information requested by the Maryland Higher Education Commission – Office of Student Financial Assistance. I also release my employer from any liability for the consequences of this release.

Signature of recipient _____Date: _____/_____/_____

Employment Information

1. Specific place of employment: _____

   Address: _____

   City: _____County: _____ State: _____Zip:_____

2. Supervisor's Name: _____ Title: _____

   Supervisor Telephone number:_____e-mail:_____

4. Name of Contact at Human Resources Department: _____

   Telephone Number: _____

   Email: _____

5. Recipient's job title: _____

6. Briefly describe primary responsibilities: _____

   _____

7. Employment status: ○ full-time ○ part-time
8. How many credit hours are you teaching: _____?
9. Dates of employment: from _____/_____/_____ to _____/_____/_____

* You may make as many copies of this form as needed.